AN EXPLORATORY STUDY OF BLACK ADULT COCAINE ABUSERS IN METROPOLITAN ATLANTA

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ABSTRACT

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Advisor: Dr. Madison Foster

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This exploratory study of Black Adult Cocaine Abusers was based on data obtained at the point of intake which was done by telephone method and conducted over a four week period at a Drug Dependence Unit of a large metropolitan hospital in Atlanta, Georgia.

The subjects were asked to respond to a questionnaire consisting of thirty-two items. There were a total of forty-one subjects, all of whom were black; twenty-two male and nineteen female. Most of the subjects were between the ages of twenty-five and thirty-two, unemployed with a yearly income of $10,000 or less. Most had completed high school and over half were single.

In terms of drug usage, most of the subjects had used cocaine for a minimum of three years, although they only considered it a problem for six months or less. The subjects all sought treatment fairly quickly after perceiving their cocaine use as a problem. In addition to cocaine the subjects used other drugs as well, with over fifty percent using marijuana. Most subjects were initially influenced to use cocaine by men and for most, external factors greatly influenced their decision to seek treatment.

Acknowledgements

The author wishes to acknowledge the staff and Clinical director of the Drug Dependence Unit of Grady Memorial Hospital for their assistance and support in obtaining the data that is presented in this study.

Sincere appreciation and gratitude is extended to the typist, D. Salvatore, for extreme patience and fortitude in assisting with the completion of this work.

Vickie M. Jester

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INTRODUCTION

Significance of the Study

Today's society is in the midst of a broad-based cocaine epidemic. There is general epidemiological agreement that a cocaine abuse epidemic is occurring in the United States starting in 1980 with the peak not having been reached. Cocaine abuse has grown from a relatively minor problem fifteen years ago to a major public health threat today. Research reveals that cocaine is the fastest growing drug of abuse in this country. It currently ranks third in level of abuse being preceded by alcohol and marijuana respectively.

A 1982 National Institute of Drug Abuse survey of 21.6 million American households, which is approximately ten percent of the total population, had tried cocaine. Almost 12 million had used cocaine in the year preceeding the survey. The number of people who had tried cocaine at least once, had increased from 5.4 million in 1974 to 21.6 million in 1982. The number of regular users rose from 1.6 million in 1977 to 4.2 million in 1984[1].

A 1984 Gallop Poll survey of males 18 years old and older showed that over 21 million had used cocaine with 7.6 million having used it in the past year and nearly 4 million were regular users[2]. Other studies estimate that between 20-24 million Americans have experimented with cocaine with approximately 5,000 "new" users daily.

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[1]Edgar H. Adams and Jack Durell, "Cocaine: A Growing Public Health Problem." National Institute on Drug Abuse Research Monograph 50: Cocaine, Pharmacology Effects and Treatment of Abuse. (DHHS Publication 1981):16

[2]Mark Gold, 800 COCAINE (Toronto, Bantam Books 1984): 21

Current reports indicate that there are 1-2 million cocaine addicted individuals in this country. Yearly, 125 tons of cocaine influxes into the United States with only fifteen percent being seized by United States agents. Americans spend forty billion dollars yearly on cocaine and six billion dollars is spent yearly on drug related law enforcement[3].

There is also a dramatic increase in both the demand for treatment and medical crises associated with increased cocaine use. Previous reports have indicated that emergency room admissions associated with cocaine use increased three and one-half times between 1976 and 1981. Since 1981 through the fourth quarter of 1983, emergency room mentions for cocaine have increased by 75 percent. Early data for 1984 indicates that approximately two thousand mentions were recorded for the first quarter of 1984. This is remarkable in that it equals the cocaine mentions for the entire year of 1978. There was a three-fold increase in the rate of cocaine-related deaths per 10,000 medical examiner reports between 1976 and 1980-1981. It is reported that in 1981 there were 195 cocaine related deaths and 580 related deaths in 1984[4].

A 1982 Center for Disease Control (CDC) report casts additional light on the dimensions of the cocaine problem. According to the CDC, more than 11,000 cocaine abusers were admitted to federally funded drug abuse programs in 1980, triple the number three years earlier. These

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[3]Larry Hart, "Cocaine. . . The Basic Details." Paper presented at the Sixth Annual Conference on Cocaine Addiction. Atlanta, Georgia September 22-23, 1986

[4]Edgar H. Adams and Jack Durell, "Cocaine: A Growing Public Health Problem." National Institute on Drug Abuse Research Monograph 50: Cocaine, Pharmacology Effects and Treatment of Abuse. (Dhhs Publication 1984):11

statistics are an underestimate since there are many admissions of cocaine abusers to private drug treatment units that are not reflected in this report[5].

Furthermore, the problem indicators associated with cocaine abuse continue to increase in part as a result of the increasing availability of cocaine, the increasing purity, and the decrease in cost. "Crack" is a powerful smokable form of cocaine that is cheap and sales are $10 to $20 per vial, making cocaine no longer an upper-middle class drug as it was in the 1970's. Cocaine is now accessible to all groups without regard to socio-economic status, race, sex and age[6].

Purpose of the Study

The purpose of this study is to fill large gaps in the general knowledge base concerning the black cocaine abuser. Until very recently, social workers, other professionals and the general public knew relatively little about the cocaine abuser and what was known came from limited case reports and laboratory experiences published in professional journals or from sensational stories in the popular media, usually involving white subjects.

Dr. Mark Gold who is the founder of the National Cocaine Hotline (800-COCAINE) which is a twenty-four hour telephone service for cocaine abusers, their families and/or anyone interested in obtaining more information on cocaine, developed a profile of the typical cocaine user.

This study provides some descriptive data of the black cocaine abuser and responds to the following questions: what kind of work do

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[5]Ibid. 12

[6]Mark Gold, 800-COCAINE, (Toronto, Bantam Books 1984): 25

they engage in, how much money do they earn, how much do they spend on cocaine, and how do they administer the cocaine. Are there similar and/or different characteristics between the participants in the 800-COCAINE survey and the participants in this study. Eighty-five percent of the respondents were white and fifteen percent were black in the 800-COCAINE survey.

The thesis is an effort to focus on the black cocaine abuser and assist in the formulation of interventive and preventive strategies in the treatment of this growing special problem group.

Scope and Limitations

This was an exploratory study that employed the telephone survey method. The study subjects included forty-one black cocaine abusers who called the Drug Dependence Unit of Grady Memorial Hospital in Atlanta, Georgia requesting services for their problems with cocaine abuse. As is the case in many studies, there were some foreseen limitations to this study.

First, the sample for this study was a sample of convenience which means that the data collected may not necessarily reflect the drug abuse population at large. While the data generated from this study cannot be generalized some useful descriptive data did emerge.

Second, the time used to collect data for the study was limited to four weeks, which in turn limited the number of participants in the study.

The study was also limited in terms of the amount of data that could be generated per questionnaire. Since this was a telephone survey, the questionnaire had to be concise, requiring no more than ten to fifteen minutes of the respondents time to ensure their participation.

This, of course, limited the number of items on the questionnaire, and in turn the amount of descriptive data that could be collected.

Another possible limitation of the study was that Grady Memorial Hospital is a public facility that primarily provides services to the indigent residents of Fulton and Dekalb counties. It may then be concluded that the sample would provide an accurate cross representation of the black population of Fulton and Dekalb counties, but that this population reflects the black indigent of the two counties thereby limiting the range of blacks represented in terms of socio-economic status, education and social class.

Finally, the instrument used in this study and developed by the author was not pretested. Therefore the validity of the instrument may be questioned.

Despite these limitations it is the author's belief that this study generated some useful descriptive statistics which should provide the impetus for further study in the area.

REVIEW OF THE LITERATURE

Historical Perspective

The substance cocaine, which is known in the drug culture as "snow," "flake," "girl," "coke," "her," "heaven leaf," and "lady" is an alkaloid derived from the leaves of Erythioxylor coca, a shrub that is cultivated in South America and to a lesser extent in Mexico, the West Indies and India. Cocaine was the first local anesthetic discovered and remains the only naturally occurring local anesthetic known to man. In it's natural form it contains Vitamin C, Riboflavin, and many B-Vitamins[7].

Use in Religion

In South America coca leaves have been used for at least 1,200 years. From 3000 B.C. to the middle of the sixteenth century, coca was used by the indigenous peoples of South America in religious, magical, medical and recreational contexts. The leaves were chewed whole or in powdered form, smoked with or without tobacco, or else swallowed in various infusions . In some cultures, it was reserved only for use by the tribal leaders and was declared divine, a gift bestowed by Marco Capay, royal son of the Sun God[8].

With the destruction of the Inca Empire in the sixteenth century, the church restricted the use of coca leaves, but cultivation and chewing of leaves was widespread. Chewing the leaves alleviated fatigue and hunger[9]. Spain dropped the ban on coca leaves when it was discovered

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[7]James V. Spotts and Franklin C. Shantz, Cocaine Users: A Representative Case Approach (New York: Free Press 1980): 3

[8]Ibid. p.4

[9]Ibid. p.4

that the Indians could not perform the heavy labor without it. During the past Inca famine, workers and slaves were paid in coca leaves to increase productivity. Later, the church recognized the economic value of coca and initiated and maintained coca plantations of its own. Coca leaves are still chewed by Andean Indians as part of the social fitual and for mild stimulant effects[10].

Use In Medicine and Recreation

Coca leaves were brought to Spain as botanical additions by Nicholas Monardes in 1569 and to England somewhat later in 1596, where by the middle of the nineteenth century it was found to have widespread medicinal uses[11].

In 1859 a German chemist, Albert Nieman, isolated the principal alkaloid from the leaves and named it cocaine. Early in 1855 Gardeke had isolated the alkaoloid and called it "erythroxylon". The medical community became enthusiastic about this new wonder drug, the medicine manufacturers exploited it and the non-medical use of cocaine for pleasure began to grow rapidly[12].

Also during that period Paulo Mantegazza, who had lived in South America, described the physiologic and therapeutic effects of coca leaves. His work heavily influenced Sigmund Freud, who during the period of 1884 thru 1887 wrote a series of papers on cocaine recommending it for depression, hysteria, hypochondria, digestive disorders and

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[10] Ibid. p. 6

[11] Ronald K. Siegel, "Changing Patterns of Cocaine Use: Longitudal Observations, Consequences and Treatment." National Institute on Drug Abuse Research Monograph 50: Cocaine Pharmacology, Effects and Treatment of Abuse (DHHS Publication 1984) p. 15

[12] Ibid. p. 93

a "cure for morphine and alcohol addiction." Dr. Carl Koller in 1884 delivered a paper on the local anesthetic effects of cocaine used topically in opthalmic surgery and became the discoverer of local anesthesia[13].

Cocaine was widely sold legally in the late nineteenth and early part of the twentieth century. In addition to numerous coca productions, cocaine itself started to appear in flake crystals, tablets, solutions for injection, ointments and nasal spray. Both coca and cocaine were also used in a variety of soft drinks. A French chemist, Angelo Marian, formulated a tonic, Vin Marians, which combined a touch of cocaine with wine and was sold to a large number of celebrities during that period. They included Pope Leo VIII, President William McKinley, sculptor Anguile Rudin, writer Jules Verne, inventor Thomas Edison and actress Sarah Bernhart[14].

At about the same time Parke-Davis, the drug company, marketed a variety of cocaine-containing products, such as cigarettes and tablets. In 1886, a Georgia chemist, Jon Styk Pemberton, formulated a patent medicine and drink whose active ingredients were cocaine and caffeine. The drink was Coca Cola. Not until 1903 was the cocaine eliminated from the ingredients[15].

The First Cocaine Epidemic

Several distinguished physicians began to report the dark side of cocaine. Medical reports of illnesses and death began to proliferate.

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[13]James V. Spotts and Franklin C. Shantz, Cocaine Users: A Representative Case Approach (New York: Free Press 1980) p.5

[14]Mark Gold, 800-COCAINE (Toronto, Bantam Books 1984) p.20

[15]Ibid. p.22

In 1891 alone, several hundred cases of cocaine toxicity and related deaths were said to have been reported. From 1890 to 1910, cases of what was thought to be cocaine addiction began appearing all over the world. The fictional detective, Sherlock Holmes, was protrayed as a cocaine user. By 1890 the failure of cocaine to cure alcohol or morphine addiction had become apparent. It was reported that the use of cocaine snuff had become an epidemic of blacks in the South. Increased crime and wholesale killing was attributed to "cocaine fiends."[16]

Cocaine snuff was a concoction composed of a small portion of cocaine mixed with some white powder to give it bulk. The drug was widely used in all sectors of society, frequently with morphine. Morphine and cocaine could be purchased relatively easy with a prescription[17].

A survey in 1902 reported that only three to eight percent of the cocaine sold in New York, Boston and other metropolitan cities went into the practice of medicine or dentistry. In 1905, several cases of cocaine and coca mania were described. Later, detailed descriptions of the symptomatology and treatment of fifteen cases of acute cocaine intoxication, some involving the use of cocaine alone and others involving mixtures of cocaine and morphine. It was reported that heavy use of cocaine was rarely an isolated habit; most commonly morphine and cocaine were used together[18].

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[16] Ibid. p. 23

[17] James V. Spotts and Franklin C. Shantz, Cocaine Users: A Representative Approach (New York: Free Press 1980) p. 9

[18] Ibid. p. 9

Decline of Use

The United States enacted the Pure Food and Drug Act in 1906. This act requires labeling of the contents of all over-the-counter preparations, forbade interstate shipments of foods and soda waters containing cocaine or opium and put the first restrictions on the import of coca leaves. In 1914 the Harrison Narcotic Act specified that anyone handling opiates or cocaine must keep records of all transactions. In 1922, Congress prohibited most importation of coca leaves and officially defined cocaine as a narcotic[19].

The passage of both these acts were due to the American Medical Association coming of age and its reactions against the excesses of patent medicine. Another factor was sheer racism. Between 1900 and 1920 the mass media raised the spector of cocaine crazed blacks committing heinous crimes. Cocaine was made to seem responsible for many murders by crazed (black) cocaine users and accused of driving more humble blacks all over the country to abnormal crimes.

During the early 1920's cocaine drifted into relative obscurity. Its medical use declined as a result of the development of longer lasting and less toxic anesthesia. Before the passage of the Harrison Act there had been quite a few pure cocaine addicts in the United States; however, by 1924 most all cocaine addicts were also addicted to opium, morphine or heroin. By the mid 1920's cocaine had gone underground in the United States and become limited largely to members of the Bohemian jazz culture and to the more affluent ghetto dwellers[20].

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[19]Ibid. p. 10

[20]Ibid. p. 9

Resurgence of Use

In the late 1960's cocaine became popular among U.S. heroin addicts both on the streets and in methadone maintenance programs. A 1969-1970 study by the New York State Narcotic Control Commission revealed that eighty-two percent used or abused cocaine. During this period cocaine was "rediscovered" and became popular among the youths in the United States. In 1970 the United States accounted for eighty-eight percent of the reported world imports of cocaine[21].

In 1961 domestic seizure of illegal cocaine by drug enforcement personnel totaled six pounds. In the late 1960's there was an alarming increase in illegal cocaine seized by the authorities. In 1970, amounts of illegal cocaine exceeded that of heroin--this was a first. Since the early 1970's, cocaine has emerged as one of the most popular illegal drugs in America[22].

Cocaine's growing popularity in the United States may be a function of the fact that it reinforces qualities that have come to be admired as truly American: initiative, drive, optimism, the need for achievement and the embrace of power.

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[21] Ibid. p. 12

[22] James V. Spotts and Franklin C. Shantz, Cocaine Users: A Representative Case Approach (New York: Free Press 1980) p. 3

General Overview of Cocaine Abuse

The literature involving scientific and social research on cocaine, its use and abuse is sparse and by no means thorough. With the current interest and the availability of federal funds, however, more research is being generated. The National Institute on Drug Abuse (NIDA) has, in the past several years, published several research monographs on cocaine, its epidemiology, physiological effects, psychological effects and treatment.

The most significant research on human beings in the past ten years has been limited to three researchers: Dr. Mark Gold, Dr. Ronald K. Seigel, and Dr. David E. Smith. Other research has included work with animals and measures of the chemical effect of cocaine on the human body. To date, no studies have examined any of the social, cultural or psychological factors that influence cocaine use in this society.

In reviewing the litereature one fact becomes amazingly clear: cocaine is a very unpredictable drug. One of the drawbacks and difficulty of researching cocaine is that there are few definites. Cocaine administered to two individuals using the same route of administration and dosage may or may not produce the same effects. A lot more research is needed before we know precisely how cocaine works and to whom it presents a danger.

Tolerance and Dependence

Despite the large amounts of cocaine some users consume, tolerance in the strict sense has not been demonstrated. In fact, there is a belief that chronic use of cocaine may lead to an increase in sensi-

tivity to its effects[23]. Furthermore, cocaine is a short acting drug, and tolerance requires a fairly constant presence of the drug in the body. Now, with the advent of more efficient routes of administration such as intravenous injection and smoking, high concentrations of the drug are achieved. Under such conditions enormous amounts can be taken and as such binges progress, a definite decreased euphoric effect occurs, indicating development of tolerance[24]. Acute tolerance has been demonstrated in animals; that is, a reduced response from a second dose of cocaine while the blood levels were still elevated from the first dose. The phenomenon called "kindling" has also been described in animals. This means that certain symptoms appear following repetitive average doses indicating a sensitization to cocaine. In humans, kindling has not yet been persuasively demonstrated[25].

Cocaine is an addictive drug. An addictive drug is one that can produce in a significant number of people three conditions: (1) compulsion, (2) loss of control, and (3) continued use of the drug despite adverse effects[26].

The physiological component of cocaine dependence may lie in the drug's powerful effect on the brain's neurotransmitters, such as norepinephrine and dopamine. Although a classical syndrome upon discontinuation of long term cocaine use has not been demonstrated, a number of post-

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[23]Larry Hart "Cocaine. . . The Basic Details" Paper presented at a Cocaine Conference, Atlanta, Georgia, Sept. 1986

[24]Sidney Cohen, M.D. Cocaine Today (New York: American Council on Marijuana and the Drug Today 1981) p. 20

[25]Ibid. p. 21

[26]Laurence Gonzales "Cocaine, A Special Report" Playboy, Sept. 1984 p. 114

cocaine symptoms emerge in high dose chronic users, especially in heavy freebase and intravenous users, including depression, insomnia, irritability, paranoia, appetite disturbance, agitation, and intense craving for cocaine[27].

Pharmacology

Cocaine is rapidly absorbed through nasal, GI tract, and rectal and vaginal mucosa and the result is local anesthesia. Cocaine in the mouth, rectum, vagina, uretha and nowe will produce blood levels within ten to twenty minutes with a peak at sixty minutes. Cocaine is extremely water soluble, but free-base is not. The volatized particles of free-base are rapidly absorbed through the alveoli[28].

The onset of the cocaine euphoric state for the various routes of administration are as follows:

A. Nasal - 2-4 minutes with peak over 10-25 minutes

B. Intravenous - 7-5 seconds with a peak over 5-10 minutes

C. Freebase - 7-10 seconds with a peak over 5-10 minutes[29]

Both the liver and the blood plasma contain the enzyme pseudocholinesterase that degrades cocaine. The half life is about one hour. The metabolites ecogonine, benzoylecgonine and norcocaine are excreted in the urine within 24 to 36 hours[30]. The limits of detection of cocaine in the urine drug screen is dependent on size of the dose, chronicity of the dose,

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[27]Arnold Washton, Ph.D., "Cocaine Abuse Treatment", Psychiatry Letter Sept. 1985, Volume II, Number 9, p. 51

[28]Larry Hart, M.D., "Cocaine . . . The Basic Details". Paper presented at Cocaine Conference in Atlanta, Georgia, Sept. 1986

[29]Ibid.

[30]Sidney Cohen, Cocaine Today, (New York American Council on Marijuana and other Drugs Today: 1981 p. 20

urine ph, urine output, time of the day and method of detection. Generally, a urine drug screen will be positive for cocaine after a single dose for 8-36 hours[31].

Physiology

Research suggests a physiological basis for the craving that follows a cocaine binge. Cocaine stimulates the limbic system, or pleasure centers in the brain. The brain is comprised of hundreds of billions of neuron cells that transmit signals through the synapses by chemicals called neurotransmitters. Cocaine is thought to interfere with chemical transmission. It blocks the synapse and prevents neurons from retrieving the reusable neurotransmitters. Stuck in the synapse, the neurotransmitters cause the receiving neuron to keep firing electrical signals in the pleasure centers[32].

The leading explanation for cocaine craving is the dopamine depletion theory. Dopamine, the neurotransmitter that radiates communication neurons to what is thought to be a major pleasure center. According to this theory, cocaine prevents the sending neurons from retrieving dopamine and the synapses become flooded with the euphoria-inducing chemical. The dopamine is then lost from the synapse, preventing neural signals from reaching the pleasure center. At the same time, the receiving neurons become super-sensitive to dopamine in a vain effort to compensate for its deficit[33].

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[31] Ibid.

[32] David Huzman "Crack Shatters the Cocaine Myth" Insight, June 23, 1986 p. 48

[33] Ibid. p. 49

Dr. Charles Dackis developed the dopamine depletion theory when he observed that cocaine addicts had high levels of the hormone prolactin, which stimulates lactation in women. Dopamine regulates prolactin. These findings have also led to the effort to treat cocaine abusers with the drug bromocriptine, which is thought to act on dopamine receptors[34].

Cocaine Studies With Animals

Research indicates that animals will work more avidly for cocaine than for any other drug. In an unlimited access situation, monkeys will self-administer cocaine by bar pressing until they die of convulsions. Primates will continue to press the bar even when it requires 12,800 responses to obtain a single dose. Monkeys prefer cocaine to amphetamines. They prefer cocaine to food even when starving, and male monkeys will keep bar pressing when a receptive female is available in another cage. They will prefer a higher dose of cocaine in spite of the electrical shock which accompanies the dose to a lower dose of cocaine without electrical shock[35].

Under limited access conditions when cocaine is available only a few hours a day, monkeys are able to regulate their bar pressing so that a fairly stable dose is received[36].

Effects of Cocaine in Pregnancy

In a study published by the National Institute on Drug Abuse in 1985, it was reported that cocaine-using pregnant women had a higher

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[34]Ibid. p. 49

[35]Sidney Cohen, Cocaine Today (American Council on Marijuana and Other Drugs of Today (New York, New York 1981) p. 34

[36]Ibid. p. 37

rate of spontaneous abortion than even women who had used herion during previous pregnancies. There is also the possibility from the present data that cocaine exposed infants are at a risk for a higher rate of congenital malformation and perinatal mortality.

Profile of the Cocaine Abuser

The majority of studies about cocaine have primarily tried to explain the phenomena of cocaine abuse; they have tried to describe the average addict. The studies have attempted to define addiction and the characteristics of it. Dr. Mark Gold was the founder of the National Cocaine Hotline. A number where anyone who has questions about cocaine may call any time day or night and ask questions or be referred to various treatment facilities around the country. Through the hotline, Dr. Gold was able to survey some 500 cocaine abusers.

The results of his study are quite interesting. First of all, Dr. Gold has labeled cocaine as basically a middle-class problem for white Americans that has reached epidemic proportions. He concluded from his data that 85 percent of all cocaine addicts were white. It is probable that a more recent survey would reveal increased use by lower socio-economic classes and minorities than in the past due to the larger availability of cheaper forms of cocaine. Cocaine is no longer a drug available only to the "affluent". The other 15 percent are Black or Puerto Rican. One out of three cocaine abusers are women. The majority are well educated and have been gainfully employed at some time during their cocaine addiction. Most of the addicts were originally introduced to cocaine by a friend or friends recreationally. Most, at the time of their seeking treatment were either using cocaine intravenously or free-basing it. However, originally all had first snorted

cocaine. Also he said that most of the cocaine addicts were extremely naive about the disease. They understood very little about the disease of addiction. Most amazing was that the majority of people who were calling because they felt that they had a problem did not actually want to discontinue the use of cocaine, but at the time of the call were experiencing extreme difficulty in procuring the drug. If unlimited and unrestricted access to cocaine was available they would continue to use cocaine. On the average, they had begun their use 4.9 years earlier.

About half of the sample were using cocaine daily at a street cost of $75 to $125 per gram. On the average, they were using about six grams per week. The week before they called the hotline, they had spent an average of $637 for cocaine with a range from about $100 to $3,200. More than nine in ten said that they had sometimes used their supply of the drug continuously until it was exhausted, no matter how much they had on hand. Despite the numerous adverse effects of the drug, these survey respondents said that they continue the use of the drug because of it's positive effects on their functioning.

Twenty-one physical side-effects and twenty psychological side-effects reported to occur when cocaine is abused were listed on the questionnaire. The replies provide clear and convincing evidence of the power of the drug to dominate it's users, even in the face of powerful negative effects. Overall, the respondents reported having suffered an average of 11 of a possible 21 physical side-effects, 12 of a possible 20 psychological side-effects, and 6 of a possible 14 social and other problems. The leading physical side-effects were chronic insomnia, reported by 82 percent, chronic fatigue, 76 percent, severe headaches, 60 percent, nasal problems, 58 percent and poor or decreased sexual perform-

ance, 55 percent.

The leading psychological problems were depression, anxiety, and irritability, each of which was reported by more than 80 percent of the sample. Paranoia, loss of interest in non-drug related activities, and difficulties in concentration were each reported by 65 percent of the sample. While 63 percent reported loss of interest in friends, fifty-four percent reported that they usually used the drug alone. Oddly, although increased sexual arousal was given as a reason for continued use of the drug, more than half, 53 percent, noted loss of sex drive. A frightening 38 percent said they had thought about committing suicide while 9 percent had actually made suicide attempts[37].

Treatment of Cocaine Abuse

Only two comprehensive efforts at cocaine abuse treatment are described in the modern literature. Both are non-pharmacological, but each involves a very different approach to treatment. Anker and Crowley have adopted the behavioral method of contingency contraction for cocaine abuse. The contract involves such contingencies as the therapist's holding letters of notification of cocaine abuse or resignation of professional licenses, written by the patient with content chosen specifically because of severe irrevocable personal effects, and mailing them to drug enforcement authorities, employers, or licensing boards upon finding evidence of cocaine use in urinalysis or after missed urinalysis. Such treatment appears to effectively induce abstinence in those willing to engage in the treatment. Anker and Crowley report 48 percent of the sample willing to engage in this treatment, with over 90 percent cocaine

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[37]Mark Gold, 800-COCAINE (Toronto, Bentam Books, 1984) p. 44

abstinence during the duration of the "contract."[38] Over half of these patients relapsed following completion of the "contract" however, even though the sample was a presumably well-motivated and educated group. The patients declining "contract" were treated with supportive psychotherapy which was also used as an additional intervention in those accepting contracts. All non-contract patients nonetheless dropped out and/or resumed cocaine abuse within 2 to 4 weeks[39].

Broader behavioral techniques have been widely applied and studied in treatment of diverse forms of drug abuse but other behavioral techniques have not been subject to outcome studies in cocaine abuse. Cocaine abusers are usually treated with more conventional psychotherapies. However, Dr. Seigel describes a treatment approach using frequent supportive psychotherapy sessions, self-control strategies, "exercise therapy," and liberal hospitalization during initial "detoxification."[40] This treatment aims at initially separating the user from the internalization of controls through psychotherapy. Half of Seigel's sample of 32 heavy cocaine smokers dropped out, but 80 percent of those remaining were cocaine-free at a nine month follow-up.

Almost all psychotherapeutic treatment of cocaine abusers can be organized around three dimensions. These are: (1) To help the abuser recognize deleterious effects of cocaine use and abuse and accept the need to stop it. (2) To help the abuser manage impulsive behavior in

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[38] Herbert D. Kleber and Frank H. Gawir, "Cocaine Abuse: A Review of Current and Experimental Treatments." The National Institute on Drug Abuse Monograph 50: Cocaine, Pharmacology, Effects and Treatment of Abuse. (DHHS Publication 1984) p. 115

[39] Ibid. p. 116

[40] Ibid. p. 118

general, and cocaine in particular; for example, exploring ways to disassociate the abuser from cocaine situations and cocaine sources. (3) To bring the abuser to the understanding of the functions that cocaine has played in his life and to help him serve these functions without drugs. For example, cocaine can serve narcissistic needs through the glamour associated with it's use. The three dimensions are present, in varying degrees, in virtually all cocaine abuse treatment programs.

Whether inpatient or outpatient treatment is indicated, and for whom is also controversial. Studies by Dr. Siegel support hospitalization, while studies by Anker and Crowley indicated that hospitalization was not necessary. It is known that relapses following hospitalization is very high[41].

Treatment of chronic cocaine abuse as currently practiced is vaguely defined and difficult to evaluate. The structured treatments of Anker and Crowley and Siegel, which are both intensive efforts, can claim long-term effectiveness in 25 percent and 40 percent of the total number of patients initially seeking treatment. A final psychological approach to cocaine abuse is the self-help group modeled after A.A. Some former abusers have reported significant help either from A.A. or N.A. (Narcotics Anonymous). Structure, group support, a religious base and availability of around-the-clock helping network have been of important assistance for some abusers. Some inpatient programs combine the confrontational group that has been long in use at residential therapeutic communities for narcotic addicts. No outcome studies of

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[41]Ibid. p. 118

these programs for cocaine abusers have been reported.

Most other cocaine abuse treatment presently being conducted has received no systematic evaluation, and is based on nonspecific psychological treatments for general substance misuse with no particular attention to the specific difficulties of cocaine abuse. Such treatment, focused on simple abstinence and psychotherapeutic management, has recently been characterized as ineffective and idealistic[42].

Single focus approaches are generally ineffective in drug abuse treatment. A number of approaches to cocaine abuse are in current use and a number of issues require resolution. Preliminary data on pharmacologic treatments are beginning to appear and show some promise. Some of the pharmacologic drugs being researched for possible treatment of cocaine abuse are Lithium carbonate, Tricyclic antidepressants, Bromocriptin, and Methylphenidate. However, it currently appears no more likely that any unimodal approach to cocaine abuse treatment will arise than it has for opiates. Integration of various approaches based on the needs of the patient seems indicated instead.

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[42]Ibid. p. 119

Research Methods and Procedures

The Setting

Grady Memorial Hospital is a public facility located in downtown Atlanta that provides services for the indigent residents of Fulton and Dekalb counties. The Drug Dependence Unit (DDU) of Grady Memorial Hospital, where this study was conducted, is an out-patient drug treatment unit specializing in the treatment of intravenous narcotic abusers, i.e., heroin abusers with the methadone drug substitution therapy.

The DDU does not provide treatment services for cocaine abusers but functions as a referral source. The DDU receives approximately ten to fifteen telephone calls weekly from residents requesting services for cocaine. The DDU staff provides these callers with the names, addresses and telephone numbers of both public and private facilities in metropolitan Atlanta that provide services for cocaine abuse according to specific demographic data, i.e., county of residence and/or medical insurance. The DDU provides this referral service each Monday through Friday between the hours of 8:00 A.M. and 4:30 P.M. Services are unavailable on weekends and holidays. The callers remain anonymous so that names and other identifying data is not requested during the telephone interview.

The Sample

The sample consisted of forty-one black adult subjects who called the Drug Dependence Unit requesting services for cocaine abuse problems between January 28, 1987 and February 28, 1987, a period of four weeks. The sample was a non-randomized sample of convenience, as the subjects consisted of any caller who agreed to participate in the study during

the specified four-week period of time. There were nineteen black females and twenty-two black males in the study.

Data Collection Procedures

The telephone survey method was employed and the author served as interviewer during the course of the study. During the four-week period of the study the author functioned as the referral source for cocaine abusers in the Drug Dependence Unit and received all telephone calls regarding cocaine abuse treatment. The author read a brief introduction (see Appendix A) stating the purpose of the study and requesting the caller's participation. If a caller agreed to participate in the study, the designated questions (see Appendix B) were asked of the caller who identified him- or herself as a cocaine abuser. No family members and/or friends who called on behalf of the abuser were included.

The Research Instrument

The instrument used in the study is a thirty-two item questionnaire developed by the author. It provides descriptive data about the subjects, e.g., age, sex, race, employment, and specific questions regarding cocaine use, e.g., length of time using cocaine, quantity, route of administration.

Statistical Treatment of Data

Due to the nature of the sample, the data was analyzed using descriptive technical techniques and is reported in terms of the means, standard deviation, frequency and percentage for each item.

THE FINDINGS

Results and Discussion

The data collected in the study provided an interesting profile of the forty-one black subjects who called the Drug Dependence Unit of Grady Memorial Hospital within the four-week data collection period. The questionnaire that was administered to the subjects was arranged so that the demographic information was listed at the end of the questionnaire. The demographic information will be discussed first so that the reader will have some idea of the subjects discussed.

As stated earlier, all of the subjects in the study were black. Sixteen (39 percent) of the subjects were between the ages of eighteen and twenty-five years. Nineteen (46 percent) of the subjects were between the ages of twenty five and thirty-two years, and six (15 percent) of the subjects were between the ages of thirty-three and forty years.

In terms of sex, twenty-two (54 percent) of the subjects were male and nineteen (46 percent) of the subjects were female. There was a fairly even distribution of male and female subjects. In the 800-COCAINE survey, Dr. Gold reported that one out of every three callers (33 percent) were females.

In the area of education, twenty-one (51 percent) of the subjects had completed high school, fourteen (34 percent) had attended high school and six (15 percent) of the subjects had some college education. The average number of years of education in the 800-COCAINE study was fourteen and the average number of years of education in this study was twelve.

Eighteen (44 percent) of the subjects were employed and twenty-three (56 percent) of the subjects were unemployed. The author had anticipated a wider margin of difference between the number of subjects

employed and unemployed, with unemployment having the greater number of subjects.

The area of yearly income is a more dismal picture. Thirty-three (81 percent) of the subjects earned ten thousand dollars or less. It is believed that if this item were subdivided further one would find that the majority of the thirty-three subjects earned a great deal less than ten thousand dollars yearly. From this, one may conclude that the subjects in this study who were employed earned a minimal wage. In the 800-COCAINE study the average income was twenty-five thousand dollars yearly.

In terms of marital status, twenty-two (54 percent) of the subjects were single, eleven (27 percent) of the subjects were married, two (5 percent) of the subjects were divorced. Table 4.1 summarizes this demographic data.

Table 4.1

Average Demographic Data

Variable	Mean	Frequency	Percent
Age	25-32 yr.	19	46
Education	12 yrs.	21	51
Employed	YES	23	56
Marital Status	SINGLE	22	54
Yearly Income	$10,000 or less	33	81

Thirty-six (87 percent) of the subjects had been using cocaine for approximately three years. Twenty-four (59 percent) of the subjects had perceived themselves as having a problem with the use of

cocaine for six months or less. Eleven (27 percent) had perceived themselves as having a problem with the use of cocaine for three to five years. In conclusion, the subjects in this study sought treatment for their cocaine use shortly after they perceived themselves as having a problem with cocaine.

Concerning the route of administration, eighteen (45 percent) of the subjects smoked cocaine, seventeen (42 percent) of the subjects used cocaine intravenously, and six (15 percent) of the subjects used cocaine intranasaly. Together smoking and injecting cocaine were the most popular routes of administration, accounting for 86 percent of the sample. Smoking and injecting are the faster methods of obtaining the effects of cocaine, but the effects also last for shorter periods of time.

Quality and quantity of cocaine used as perceived by the subjects is also of interest. Thirty-three (81 percent) of the subjects used cocaine daily. One (2 percent) of the subjects used cocaine weekly. Finally, seven (17 percent) of the subjects used cocaine more than once a week. The subjects in this study were regular and frequent users of cocaine.

Twenty-four (59 percent) of the subjects responded that the most cocaine they had ever consumed in a day was one gram. Two (5 percent) of the subjects reported having used less than one-half gram in a day. Fifteen (37 percent) of the subjects reported that the most cocaine they had consumed in one day was more than a gram.

In terms of actual cost, eighteen (44 percent) of the subjects responded that the most money they had ever spent on cocaine in one day was $200. Fifteen (37 percent) of the subjects reported having spent

$100 in one day. Six (15 percent) of the subjects reported that the most money that they had ever spent on cocaine in one day was $500. This data is ambiguous because of the author's inability to determine the relationship between these two items and whether the results reflect a one-time episode for the cocaine user or a more frequent occurrence.

In this study twenty-nine (71 percent) of the subjects reported that they perceived the cocaine which they used as being eighty-five to ninety percent pure. Six (15 percent) of the subjects perceived the cocaine as being one hundred percent pure. Five (12 percent) of the subjects perceived the cocaine used as being fifty percent pure. The cocaine used in smoking may indeed be of greater purity when compared to cocaine that is injected or snorted because of teh processes it undergoes before it is smoked. Table 4.2 represents a summation of the most frequent responses given regarding the quality and quantity of cocaine used as perceived by the subjects in this study.

Table 4.2

Quality and Quantity of Cocaine Used

Variable	Mean	Frequency	Percent
Quantity used	1 gram	24	59
Money spent	$200	18	44
Frequency used	daily	33	81
Purity	85%-90%	39	71

All of the subjects (100 percent) in the study reported that they used other drugs besides cocaine. Twenty-six (63 percent) of the subjects reported that they used marijuana. Nine (22 percent) of the subjects reported that they drank alcohol. Six (15 percent) of the subjects

reported that they used heroin. Table 4.3 represents these results.

Table 4.3
Drugs Used Other Than Cocaine
N=41

Drug	Frequency	Percent
Marijuana	26	22
Alcohol	9	63
Heroin	6	15

It appears that the subjects in this study used other drugs which produce a sedative effect for the users of cocaine which is consistent with the literature. Dr. Mark Gold stated in his book 800-COCAINE that few cocaine users restrict their drug use to cocaine and often use drugs to counter the stimulant effects of cocaine.

Cocaine was reported as the drug of choice for thirty-five (85 percent) of the subjects. The remaining six (15 percent) of the subjects reported that cocaine was not their favorite or drug of choice.

Several items on the questionnaire examine socialization and cocaine use. Forty (98 percent) of the subjects reported using cocaine when in the presence of others who were also using cocaine. Twenty-three (56 percent) of the subjects reported that they used cocaine alone and used cocaine in the absence of other cocaine users. Eighteen (44 percent) of the subjects reported that they always used cocaine in the presence of other cocaine users. In summary, it appears that most of the subjects in the study used cocaine in the presence of other cocaine users in addition to using cocaine alone at times.

Thirty-five (85 percent) of the subjects responded that they were influenced to use cocaine initially by men. Only six (15 percent) of the subjects were initially influenced to use cocaine by women. It appears that cocaine is a drug that is often introduced to the user by men.

Twenty (49 percent) of the subjects responded that the person who influenced them to first use cocaine was a friend. Twelve (29 percent) of the subjects responded that the person who initially influenced them to use cocaine was a relative. Nine (22 percent) of the subjects responded that they were initially influenced to use cocaine by a lover. Twenty (49 percent) of the subjects responded to having known the person who initially influenced them to use cocaine six months or less before using cocaine. Twelve (29 percent) of the subjects reported to having known the person who initially influenced them to use cocaine for one year before using cocaine. Nine (22 percent) of the subjects reported to having known the person who initially influenced them to use cocaine for two years or more prior to their first use of cocaine. Finally, twenty-five (61 percent) of the subjects reported still maintaining contact with the person who initially influenced them to use cocaine. Sixteen (39 percent) of the subjects reported that they do not have contact with the person who initially influenced them to use drugs. Table 4.4 provides a profile of the person who initially influenced the subjects in this study to use cocaine, utilizing the most frequent responses.

Table 4.4

Profile of the Inducer to Use Drugs

N=41

Variables	Mean	Frequency	Percent
Sex of inducer	Male	35	85
Relationship	Friend	20	49
Contact prior to use	0-6 mos.	20	49
Maintained contact	Yes	25	61

In this study thirty-four (83 percent) of the sample reported that they perceived women as using more cocaine than men. Seven (17 percent) of the subjects perceived men as using more cocaine than women. Cocaine was purchased by thirty-five (85 percent) of the subjects through their own resources, while six (15 percent) of the subjects expressed that they received cocaine as a gift.

Let us now look at that part of the study which examined the relationship between cocaine use and sexual relationships. Twenty-three (56 percent) of the subjects reported that they never engaged in sexual activity in exchange for cocaine. Twelve (29 percent) of the subjects reported that they engaged in sexual activity in exchange for cocaine. Six (15 percent) of the subjects did not respond to this item. Of the twelve (29 percent) subjects who reported to having engaged in sexual activity in exchange for sex, sixty-seven percent reported that they seldom engaged in sexual activity in exchange for cocaine. Eleven percent of the subjects reported that they always engaged in sexual activity in exchange for cocaine and twenty-two percent of the subjects report that they often engage in sexual activity in exchange for cocaine.

Twenty (49 percent) of the subjects reported that they had exchanged cocaine for sexual activity with another person. Twenty-one (51 percent) of the subjects reported that they never exchange cocaine for sexual activity with another person. Of the twenty subjects who reported to having exchanged cocaine for sexual activity with another person, seventy-seven percent reported that this occurred seldom and twenty-three percent reported that they often exchange cocaine for sexual activity with another person.

In both instances, i.e. engaging in sexual activity for cocaine and exchanging cocaine for sexual activity, less than half of the subjects gave affirmative responses. While it appears that there is some relationship between sexual activity or relationships, and the exchange of cocaine the author cannot draw any conclusions regarding the nature and magnitude of that relationship based on the data. Table 4.5 compares the affirmative responses on these two items.

Table 4.5

Sexual Activity and Cocaine Use

Variable Positive Responses	Frequency	Percentage
Engage in sexual activity for cocaine	12	29
Exchange cocaine for	20	49

Table 4.6 summarizes the responses of the subjects in this study who reported that they engaged in sexual activity in exchange for cocaine.

Table 4.6
Sexual Activity in Exchange for Cocaine
N=12

Frequency	Percent
Seldom	67
Often	22
Always	11

Table 4.7 summarizes the responses of the subjects in this study who reported that they exchange cocaine for sexual activity.

Table 4.7
Cocaine in Exchange for Sexual Activity
N=20

Frequency	Percent
Seldom	77
Often	23

In exploring the number of times in which the subjects sought treatment for their cocaine use thirty-five (85 percent) of the subjects were requesting treatment for the first time. Six (15 percent) of the subjects were requesting treatment for the second or third time. In addition, thirty-five (85 percent) of the subjects had sought treatment for the first time within a six-month time span.

External factors influenced the subjects in this study to request treatment for their cocaine abuse. Sixteen (39 percent) of the subjects reported to seek treatment because of financial problems. Eight (20 percent) of the subjects reported to seeking treatment because of family problems. Two (5 percent) of the subjects reported to seeking

treatment because of legal problems. Fifteen (37 percent) of the subjects reported to requesting treatment for their cocaine use because they believed they were addicted to cocaine.

Implications of Study for Future Research

This study has several implications for further study. First, it is the opinion of the author that this study needs to be expanded in terms of the number of subjects and time used in conducting the study. It is the author's belief that this study was limited in terms of time for collection of data and sample size which may mean that this data cannot be generalized to the larger black adult cocaine abuser population. It may reflect the population sample only; other studies using larger samples are needed.

This study also gives rise to several hypotheses that can be further tested such as: (1) Do men assert a greater influence on cocaine use in this society than women? According to the data produced in this study, eighty-five percent of the subjects were initially influenced to use cocaine by men. (2) Are there further differences in the influence of cocaine use across sexes? (3) Do men exert a greater influence on women to use cocaine than do other women? If so, does the influence that is exerted by men also have an impact on women seeking and receiving treatment and the outcome of that treatment? If the answers to these questions are yes, how can treatment services be structured to address these concerns?

Second, in this study, eighty-three percent of the respondents perceived women as consuming larger quantities of cocaine then men consume. (1) Do women indeed consume larger quantities of cocaine than men? Can this difference in drug use based on sex be measured quantita-

tively? If this hypothesis is proven empirically, is there some biological basis for the sex differences? Do the hormones epinephrine and norephrine, which are involved in the physiological consequences of cocaine in the body, have a role in this difference, or are the differences based on psychological factors?

Finally, the data from this study indicate that cocaine abusers are influenced to seek treatment when they are impacted by outside forces such as legal and financial problems. Can an actual parallel be drawn between cocaine abusers and intravenous narcotics abusers who often seek treatment because of outside influences? Are the cocaine abusers motivated to seek treatment only when they experience legal, financial and family difficulties as opposed to actually seeking treatment to discontinue use of the drug?

Implications of Study for Further Social Work Interventions

The study has several implications for social work interventions. As stated earlier in the study, there is a dearth of available literature and research on cocaine abuse and the cocaine abusers. The Social Worker can intervene first by being researchers themselves. The hypotheses set forth for further study in the previous section of this paper can be an excellent starting point for the social worker. The social worker should be active and take leadership roles in furthering the knowledge on cocaine abuse and serve as a catalyst to stimulate research in this area. The social worker can advocate for increased funding of research programs on cocaine abuse.

The study indicates that the cocaine abuser is often influenced to seek treatment by outside factors, i.e., legal problems, financial problems and family problems. The social worker can intervene on the individual

level of cocaine abuse using systems, theory and other basic skills and knowledge of social work.

Once more solid knowledge on cocaine abuse is established, the social worker can develop more successful methods of treatment. Even with this dearth of knowledge on cocaine abuse, the social worker can still intervene in her role of educator by educating the general public and the individual cocaine abuser about the effects of cocaine abuse. As the society struggles with the current cocaine epidemic the social worker can facilitate in the area of research and with the individual in his efforts at discontinuing the use of cocaine.

Summary and Conclusions

Cocaine abuse has reached epidemic proportion in this society. It is generally accepted that cocaine abuse has exceeded all limits in terms of race, sex and socioeconomic status. Yet, cocaine is still referred to as the middle-class high and the only profile done of the typical cocaine abuser describes him as being white, male, having a fourteen year education and and average salary of $25,000. Further literature needs to be done to address the black cocaine user who may not fit this picture if my data is representative of the black users of cocaine.

The author proposes a profile of the black cocaine abuser. This study was conducted over a four-week period of time. It was an exploratory study that employed the telephone survey method. Data was collected on forty-one subjects, all black, who called the Drug Dependence Unit of Grady Memorial Hospital in Atlanta, Georgia.

The subjects were almost evenly divided across sex, with twenty-two of the subjects being male and nineteen subjects being female. The majority of the subjects were between the ages of twenty-five and thirty-two. Fifty-one percent of the subjects completed high school and thirty-four percent had attended high school. In terms of employment, fifty-six percent of the respondents were unemployed and forty-four percent were employed. Fifty-four percent were single, fifteen percent divorced. Most had income levels that located them in the lower-economic status with eighty-one percent of the sample earning less than $10,000 yearly.

Most of the participants in the study had abused cocaine for three years, but only considered cocaine a problem for six months or less.

They sought cocaine treatment soon after perceiving their drug abuse as a problem. The subjects used cocaine daily and eighty percent of the subjects smoked or injected cocaine. All of the participants used other drugs besides cocaine, primarily marijuana; yet cocaine was the drug of choice for eighty-five percent of the sample. Many of these subjects used drugs with other drugs even though they occassionally used cocaine alone.

An interesting finding was that eighty-five percent of the sample reported that they were initially influenced to use cocaine by men. There may be some relationship between sexual favors and cocaine, but the extent of the relationship is not clear. The respondents were seeking treatment for cocaine abuse for the first time and outside factors had a great influence on the subjects seeking treatment.

This study has implications for further study in several areas. First, before the results of this study can be generalized to the larger adult black cocaine population, a study using a larger sample population should be conducted. This study or studies could explore several hypotheses to include: (1) What effect does sex exert in influencing people to use cocaine?; (2) comparison on quantities of cocaine consumption between males and females; and (3) the relationship that outside factors, such as legal and financial problems, exert on the cocaine abuser to seek treatment and to discontinue use of cocaine.

There is a great need for further study in the field of cocaine abuse and the social worker should play an important role in devising and implementing various interventions for cocaine abuse.

Appendix A

Explanation of and Agreement to Participate in Study

"Hello. My name is Vickie Jester. I am an Atlanta University student working on a Master's Degree in Social Work. I am conducting a study on cocaine abuse and the people who use cocaine. It would be helpful if you would answer some questions about your cocaine use. All information that you provide is confidential and will be used only to increase the available knowledge and understanding of cocaine abuse. Your identity will not be revealed, for I don't need your name or any other identifying information. You will not be contacted again by me relative to your use of cocaine. Participation in this study is strictly voluntary and you do not have to answer any questions with which you feel uncomfortable. At the end of the interview, I will give you the name and telephone number of an agency or agencies that provide treatment for cocaine abuse. The more information you provide, the better able I will be to link you with the best agency to meet your specific needs. Would you like to participate in this study?

_____Yes _____No

Instructions

The following questions are to be answered in terms of your personal experience with cocaine. After each question you will be given several possible responses. Please select the response which best describes your experience with cocaine.

Appendix B

Questionnaire

1. For what period of time have you used cocaine?

3-6 mos. 1 yr. 2 yrs. 3-5 yrs. 5 yrs. or more

2. For what period of time have you considered cocaine a problem?

3-6 mos. 1 yr. 2 yrs. 3-5 yrs. 5 yrs. or more

3. Which of the following is your most frequently used method of use for cocaine?

smoke inject snort

4. How often do you use cocaine?

daily weekly more than once a week less than once a week whenever possible

5. What is the most cocaine you yourself used in a day?

¼gram or less ½gram or less 1 gram more than 1 gram

6. What is the most money you have spent on cocaine in a day?

$50 $100 $200 $300 $500 or more

7. Which of the following best describes the purity of the cocaine you use?

25% 50% 75% 85%-95% 100%

8. Do you use other drugs besides cocaine? Yes No

9. If yes, what other drugs? (check one)

alcohol marijuana barbiturates heroin or narcotics N/A

10. Is cocaine your favorite drug? Yes No

11. Do you ever use cocaine with other people? Yes No

12. Do you ever use cocaine alone? Yes No

13. You were encouraged to first use cocaine by a member of what sex?

Male Female

14. What relationship was that person to you?

friend relative lover spouse

15. Over what period of time did you have contact with this person before they encouraged you to use cocaine?

0-6 mos. 1 yr. 2 yrs. 3-5 yrs. more than 5 yrs.

16. Do you still have contact with this person? Yes No

17. Who do you think uses more cocaine? Males Females

18. Which of the following is your most frequently used method of obtaining cocaine?

buy gift

19. Have you ever had sex with someone in exchange for cocaine?

yes No No answer

20. If yes, how often does this occue?

seldom often very often always

21. Have you ever given someone cocaine in exchange for sex? Yes No

22. If yes, how often does this occur?

seldom often very often always

23. How many times have you sought treatment for cocaine abuse?

once 2-3 4-5 5 or more

24. When was the first time you sought treatment for cocaine abuse?

0-6 mos. 1 yr. 2 yrs. 3-5 yrs. 5 yrs. ago

25. Which of the following best describes your reason for seeking treatment at that time?

legal problems
financial problems
family/marital problems
unable to control use
want to discontinue use of cocaine

26. Age _____ years.

27. Sex_____

28. Race _____

29. Education _____ years.

30. Employed? Yes No

31. Marital status:

single married separated widowed divorced

32. Monthly income:

0-$10,000
$10,000 - $15,000
$15,000 - $20,000
$20,000 - $25,000
$25,000 and above

Selected Bibliography

Books

1. Bennett, Gerald, Vourakis, Christine, and Would, Donna S. Substance Abuse: Pharmacologic Developmental and Clinical Perspectives. New York: John Wiley and Sons, 1983.
2. Cohen, Sidney. Cocaine Today. New York: American Council on Marijuana and Other Psychoactive DRugs, Inc. 1981.
3. Spotts, James V., Shantz, Franklin. Cocaine Users. New York: The Free Press, 1980.

Government Publications: National Institute of Drug Abuse

4. Adams, Edgar H., Durell, Jack. "Cocaine: A Growing Public Health Problem." Cocaine: Pharmacology, Effects and Treatment of Abuse. Research Monograph 50, 1984.
5. Beschner, George M., Reed, Beth Glover, and Mondanard, Josette. Treatment Services for Drug Dependent Women. Vol. 1. Washington, National Institute on Drug Abuse.
6. Chasnoff, Ira J., Burns, William J., Schnoll, Sidney H., and Burns, Kayreen A. "Effects of Cocaine on Pregnancy Outcome." Cocaine Problems of Dependence. Research Monograph 67, 1985.
7. Kleber, Herbert D. and Gawin, Frank. "Cocaine Abuse: Review of Current and Experimental Treatment." Cocaine: Pharmacology Effects and Treatment of Abuse. Research Monograph 50, 1984.

8. Siegel, Ronald K. "Changing Patterns of Cocaine Use." Cocaine Pharmacology, Effects and Treatment of Abuse. Research Monograph 50, 1984.

9. Dackis, Charles A., Gold, Mark S. "Bromocriptin Treatment of Cocaine Addiction. Psychiatry Letter (August 1985): 45-50.

10. Gold, Mark S. "Adolescent Cocaine Epidemic." PharmChem Newsletter 15, 1-8.

11. Gold, Mark S., Verebey, Karl, and Dackis, Charles. "Diagnosis of Drug Abuse, Drug Intoxication and Withdrawal States. Psychiatry Letter (May 1985): 23-24.

12. Khantzian, E. J. "On the Psychological Predisposition for Opiate and Stimulant Dependence." Psychiatry Letter (January 1985).

13. Mittelman, Hollace S., Mittleman, Roger E., and Elsner, Bernard. "Cocaine." American Journal of Nursing 45. (Sept. 1981). 1093-1096

14. Renfroe, Charles. "Report of a National Cocaine Conference in San Francisco." Grassroots (December 1983).

15. Shoemaker, Kenneth. "Concept of Addiction." Journal of the Medical Association of Georgia 45 (March 1976).

16. Smith, David E. "Cocaine and Alcohol ABuse: Epidemiological, Diagnostic and Treatment Consideration." Journal of Psycho-

17. Smith, David E. "Cocaine and Alcohol Abuse: Epidemiological, Diagnostic and Treatment Consideration." Journal of Psychoactive Drug. 18-2 (April - June 1986).

18. Smith, David E. and Wesson, Donald R. "Cocaine." Journal of Psychedelic Drugs, 10 (October - December 1978).

19. Tennant, Forest S. Jr., et. al. "Treating Cocaine and Amphetamine Dependence with Desipramine." Stimulants (November 1983).

20. Washton, Arnold. "Cocaine Abuse Treatment." Paychiatry Letter, (September 1985): 51-56.

Magazine Articles

21. Atkinson, Holly. "Cocaine: Could You Get Hooked?" New Woman, June 1986.

22. "Battle Strategies." Time, 15 September, 1986.

23. Beck, Melinda. "Cocaine, the Evil Empire." Newsweek, 25 Feb., 1985.

24. Cate, Benjamin W.; McWhiter, William; and Simpson, Janice C. "Crashing on Cocaine." Time, 11 April, 1983.

25. Demarest, Michael. "Cocaine: Middle Class High." Time, 6 July, 1986.

26. Gonzales, Lawrence. "Cocaine: A Special Report." Playboy, September 1984.

27. Hamburg, Margaret. "Addiction: Quitting is the New High." Vogue, August 1986.

28. Heller, Ann. "Something Wicked: Crack, Black Tar Heroin-- The New Users." Mademoiselle, September 1986.

29. Lamar, Jacob V. "Crack, a Cheap and Deadly Menace." Time, 2 June, 1986.

30. Langway, Lynn, and Friendly, David T. "Kicking The Cocaine Habit." Newsweek, January 1983.

31. Seligman, Jean, McKillop, Peter, Greenbert, Nikki Finke, and Burgower, Barbara. " Crack, the Road Back." Newsweek, 30 June 1986.

32. Tyndall, Katie. "Crack Shatters the Cocaine Myth." Insight, 23 June, 1985

33. Wilbur, Robert. "A Drug to Fight Cocaine." Science, March 1985.

Unpublished Materials

34. Hart, Larry R. "Cocaine. . . The Basic Details." Paper presented at the Sixth Annual Conference on Cocaine, Atlanta, Georgia, 20 September 1986.